

STATE OF CONNECTICUT
Department of Developmental Services, Division of Autism Spectrum Services
460 Capitol Avenue • HARTFORD, CONNECTICUT 06106

PROVIDER AGREEMENT

Date: _____

Agreement between the Connecticut Department of Developmental Services (DDS) and

Provider: _____

Address: _____

Phone: _____ Fax: _____

The provider agrees to accept check(s) for item(s) or service(s) purchased for individuals served through the DDS Autism Program. Financial management, for these purchases, is provided by DDS contracted fiscal intermediaries, which is not a Connecticut government agency. Acceptance and endorsement of the check(s) will signify that the provider agrees to the following terms and conditions:

- a. Accept payment, in form of check(s), from DDS contracted fiscal intermediaries doing business in Connecticut.
- b. Agree to keep records of the service(s) or purchase(s).
- c. Provide only the service(s) or item(s) authorized on the check(s).
- d. Accept the check(s) as payment in full for the service(s) or item(s) purchased.
- e. No additional charges will be made or accepted from clients.
- f. Upon request, provide DDS or its designee information regarding the service(s) or purchase(s) for which payment was made.

DDS Autism Representative

Provider Representative